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200. INTRODUCTION TO THE CASE MIX ASSESSMENT PROCESS

A. THE ASSESSMENT PROCESS. The resident assessments used to compute a facility's average case mix weight are completed by Peer Review Organization's Registered Nurses. Assessments reflect the resident's condition on a date assigned by the reviewer to be the target date. The assessment shall be based on a review of the resident's medical record. The Peer Review Registered Nurses or Coordinators are to physically observe the resident to determine if the resident's medical record is congruent with the mental status and physical condition of the resident.

B. FREQUENCY OF ASSESSMENT. During each assessment quarter, the Peer Review Organization (PRO) contractor shall assess all Nursing Facilities which participate in the Kentucky Medicaid Program. Assessment quarters are as follows: December through February, March through May, June through August, and September through November.

C. SCOPE OF ASSESSMENTS. The PRO contractor shall assess all residents including hospice patients for whom Medicaid is the Primary Payor or Co-insurer of benefits who are either present in the facility or on leave on the target date.

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The facility shall be responsible for providing a complete list of Medicaid residents to the reviewer. This list shall include all residents who receive Medicaid benefits for any portion of their stay and all those in pending Medicaid status.

D. FEEDBACK FROM ASSESSMENTS.

The reviewer shall hold an exit conference upon completion of the facility case mix review. At this time the reviewer shall provide information relating to the assessments. Participation of the facility administrator or Director of Nursing in these conferences will promote a better understanding of the system and process.

E. ASSESSMENT APPEAL PROCESS.

1. Reconsideration by the PRO. If the provider disagrees with any of the resident assessments performed by the PRO contractor and would desire to have the PRO contractor reconsider the assessment classification, the provider shall notify the PRO contractor in writing of their desire to have the assessment classification(s) reconsidered. This request for reconsideration shall be postmarked within seven (7)

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days of the provider having been informed of the original assessment by the PRO. Requests for reconsideration shall be made on KMAP form MAP-575.

This form shall be filled out completely including an explanation as to the reasons for asking that the classification be reconsidered. The provider shall also attach a copy of the original assessment with areas of disagreement circled and copies of any documentation which shall support their request for reconsideration.

No reconsideration shall be made unless the item(s) being contested have the potential of changing the resident's overall classification. Requests for reconsideration which are based upon disagreement with case mix policy only shall not be considered by the PRO contractor but shall be referred to the Department for Medicaid Services.

If the review agency receives a properly filed request for reconsideration, the PRO shall conduct a second assessment of the resident within seven (7) days of the receipt of the request. The PRO staff conducting the reconsideration shall not include anyone who

participated in the original assessment. Copies of the assessments completed during the reconsideration process shall be given to the provider at the completion of the reconsideration process The reconsideration shall be limited to those factors having a bearing on the resident's classification.

The assessment performed during the reconsideration process shall be used in lieu of the original assessment. This is regardless of whether the second assessment is higher or lower than the first assessment.

2. **Appeal to the Assessment Review Panel. If after the reconsideration of the assessment(s) by the PRO, the provider does not agree with the assessment(s) performed by the PRO, the provider may appeal the assessments to the Assessment Review Panel if the following conditions are met:**

   a. The appeal is made in writing and is postmarked within thirty (30) days of the completion of the reconsideration.

b. The request explains in detail the reason for the appeal for each assessment being appealed. Copies from the medical record to support this request shall be included.

c. The provider has properly utilized the re-consideration process available through the PRO for the assessment area being appealed.

d. The assessment(s) being appealed have the potential of changing the provider's average case mix weight by .01 or more for that particular quarter.

The Assessment Review Panel shall be chaired by the Director of the Division of Patient Access and Assessment or the Director's designee. The remaining two members shall be Registered Nurses. One of the Registered Nurses shall be an employee of the Department for Medicaid Services. The other Registered Nurse shall be an individual from the Nursing Facility industry.

A date for the Assessment Review Panel to convene shall be established within twenty (20) days of the receipt of a written request for such an appeal. The Panel shall issue a binding decision on the appealed assessments within thirty (30) days of the hearing. These timeframes may be waived by mutual consent of the provider and the Panel.

F. Quality Assurance

The Department for Medicaid Services has established a Case Mix Quality Assurance Program. The Quality Assurance staff members are Registered Nurses who perform a sample of resident assessments in the wake of the PRO reviewers. Problems discovered by the sampling strategy are brought to the PRO's attention for appropriate corrective action. Resident assessments performed by the Medicaid Quality Assurance staff will not, however, directly change individual assessments performed by the PRO reviewers.

201. RESIDENT ASSESSMENT

A. ELEVEN ASSESSMENT STANDARDS USED TO DETERMINE CLASSIFICATION/REIMBURSEMENT. Under the CMAR system 11 assessment standards affect classification/reimbursement. These standards reflect the care needs of the resident. The items are 8 Key Activities of Daily Living and 3 additional variables which are Behavior, Special Nursing Treatments and Clinical Monitoring.

B. **CRITERIA FOR 8 KEY ACTIVITIES OF DAILY LIVING. In order to determine the proper score under an Individual Dependency, the resident's medical record shall establish that within twenty-one (21) days of a new admission or following a significant change in resident condition requiring an MDS reassessment the three (3) criteria listed below shall be met in their entirety. When the following three (3) criteria are not met, the client shall be assigned a score of "0" (independent) in all eight ADL's except for those residents exempted by Section 204:**

1. The physician has performed a medical evaluation of the resident. A physician evaluation may take many forms. Some examples are: history/physical records, progress notes stating the exam was completed, a note by the doctor on a hospital

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discharge summary stating that it is accepted as the evaluation or an exam from a previous admission which has a statement by the physician stating it is acceptable as the current evaluation.

2. A registered nurse has coordinated a resident assessment;

A registered nurse shall not be obligated to specifically perform all aspects of the resident assessment; however, a registered nurse shall at a minimum coordinate the various portions of the assessment which are performed by other staff, and the registered nurse shall sign the assessment, thereby attesting to the co-ordination and oversight. Nursing assessments which are performed to meet the requirements of the MDS system will also fulfill the nursing assessment requirements of the case mix system. If the resident was admitted prior to October 1, 1990, and an L.P.N. performed the assessment without R.N. coordination this shall constitute an acceptable nursing assessment until the MDS system is fully implemented.

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3. A written comprehensive plan of care has been developed and maintained except for those exempted under Section 204; and

C. ACTIVITIES OF DAILY LIVING (ADL) AND SCORING FOR DEPENDENCIES. Each ADL shall be addressed individually in the medical record. Blanket statements such as, "Dependent in all ADL's," shall not be acceptable.

ADL's shall be coded using nursing summaries, nurse's notes, checklists, etc. The coding shall reflect the trend of the charting. In cases where both the nursing summary and the daily information are not consistent, the daily shall override.